

01921

MARYLAND 1937

STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

Reg. Dist. No. 251

1. PLACE OF DEATH: COUNTY <u>QUEEN ANNES</u> MARYLAND CITY (If outside corporate limits, write RURAL and OR give nearest town) <u>MILLINGTON</u> X TOWN <u>MILLINGTON</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>00</u>				2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <u>MARYLAND</u> COUNTY <u>QUEEN ANNES</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>MILLINGTON</u> OR TOWN <u>MILLINGTON</u> STREET ADDRESS (If rural, give location) <u>1</u>			
3. NAME OF DECEASED (Type or Print) <u>WILLIAM</u> (First) <u>HALL</u> (Middle) <u>BONWILL</u> (Last) 4. DATE OF DEATH <u>FEB. 27</u> 19 <u>55</u>				5. SEX <u>MALE</u> 6. COLOR OR RACE <u>WHITE</u> 7. SINGLE, MARRIED, WIDOWED, DIVORCED, <u>WIDOWED</u> 8. DATE OF BIRTH <u>APRIL 9, 1869</u> 9. AGE last birthday <u>85</u> yrs. 11 under 1 year 12 under 24 hrs Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>RETIRED</u>				11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>EUGENE M. BONWILL</u>				14. MOTHER'S MAIDEN NAME <u>PENNINGTON</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If year, give war or dates of service) <u>—</u> 16. SOCIAL SECURITY No. <u>NONE</u>				17. INFORMANT AND ADDRESS <u>EMORY BONWILL CHESTERTOWN, MD.</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
331X Immediate cause (a) <u>Cerebral Hemorrhage</u>						<u>2 weeks</u>	
Antecedent cause(s) (b) <u>Generalized Arteriosclerosis</u>						<u>several years</u>	
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>none</u>							
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>none</u>							
19a. DATE OF OPERATION <u>none</u>				19b. MAJOR FINDINGS OF OPERATION <u>—</u>		20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>	
21. ACCIDENT SUICIDE HOMICIDE (Specify) <u>—</u>				PLACE (Home, farm, factory, street, OF office bldg., etc.) <u>none</u>		(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>none</u> m.				INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>		HOW DID INJURY OCCUR? <u>none</u>	
22. I hereby certify that I attended the deceased from <u>Feb 26</u> , 19 <u>55</u> , to <u>Feb 27</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>Feb 26</u> , 19 <u>55</u> , and that death occurred at <u>1:30</u> p.m., from the causes and on the date stated above.							
SIGNATURE <u>J. H. Hamilton</u>				ADDRESS <u>M. D. Millington MD</u>		DATE SIGNED <u>Feb 27/55</u>	
23. BURIAL, CREMATION REMOVAL (Specify) <u>BURIAL</u>		DATE <u>MAR. 1, 1955</u>		NAME OF CEMETERY OR CREMATORY <u>STILL POND CEMETERY</u>		LOCATION (City, town, or county) (State) <u>STILL POND MD.</u>	
DATE REC'D BY LOCAL REG. <u>Mar. 3</u>		REGISTRAR'S SIGNATURE <u>Edgar A. Lane</u>		24. FUNERAL DIRECTOR <u>B. P. Fellows</u>		ADDRESS <u>STILL POND, MD.</u>	

MARGIN RESERVED FOR BINDING

BUREAU V. S.

MAR 7 1955

RECEIVED

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1938

01923

Reg. Dist.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

No. 252

1. PLACE OF DEATH: COUNTY <u>Queen Anne's</u> MARYLAND CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Rural Centerville</u> TOWN <u>Centerville</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS				2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <u>Maryland</u> COUNTY <u>Queen Anne's</u> CITY (If outside corporate limits write RURAL and give nearest town) <u>Rural Centerville</u> OR TOWN <u>Centerville</u> STREET ADDRESS (If rural, give location) <u>Perles, Quantown Road</u>			
3. NAME OF DECEASED: (Type or Print) <u>WILLIAM (First) MARION (Middle) COUNCELL (Last)</u>			4. DATE OF DEATH <u>July 12</u> 19 <u>51</u>				
5. SEX: <u>Male</u>		6. COLOR OR RACE: <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Single</u>			
8. DATE OF BIRTH: <u>July 31-1889</u>		9. AGE last birthday: <u>65</u> yrs.		10. IF UNDER 1 YEAR: Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>Retired</u>			10b. KIND OF BUSINESS OR INDUSTRY: <u>From Georgetown</u>				
11. BIRTHPLACE (State or foreign country): <u>Centerville Maryland</u>			12. CITIZEN OF WHAT COUNTRY? <u>USA</u>				
13. FATHER'S NAME: <u>Robert H Cancell</u>			14. MOTHER'S MAIDEN NAME: <u>Martha Ann Sparks</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>Yes</u> (If Yes, give war or dates of service) <u>WW #1</u>			16. SOCIAL SECURITY No.: <u>1701Batter St Baltimore Md</u>				
17. INFORMANT & ADDRESS: <u>Ann Lillian C Rouse</u>			18. MEDICAL CERTIFICATION				
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH: <u>420.1</u> Immediate cause (a) <u>Coronary Occlusion</u> DUE TO Antecedent cause(s) (b) <u>He was found dead in a snow drift in his yard - He has had heart disease for last 24</u> DUE TO Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c) <u>his yard - He has had heart disease for last 24</u>					INTERVAL BETWEEN ONSET AND DEATH		
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION: <u>0</u>			19b. MAJOR FINDING OF OPERATION:				
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.					
21a. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY		21b. (City or town) (County) (State)					
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED White at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . SIGNATURE <u>W. Henry Fairclough M.D.</u> CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>2/15-55</u> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAM. <input type="checkbox"/>							
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>		DATE THEREOF: <u>Feb 16-55</u>		NAME OF CEMETERY OR CREMATORY: <u>Centerville Maryland</u>			
24. FUNERAL DIRECTOR		LOCATION (City, town, or county) (State)					
DATE REC'D BY LOCAL REG. <u>2-15-55</u>		REGISTRAR'S SIGNATURE: <u>Oliver K. Kesterson</u>					
25. ADDRESS		26. ADDRESS					

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FEB 21 1955

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1939

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

01924

CERTIFICATE OF DEATH

Reg. Dist. No. 254

tem 11, Film G178 3-15-55 et

1. PLACE OF DEATH- COUNTY <u>Queen Anne's</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Md.</u> COUNTY <u>Q.A.</u>	
CITY (if outside corporate limits, write RURAL and OR give nearest town) TOWN <u>Grassville</u>		CITY (if outside corporate limits, write RURAL and give nearest town) TOWN <u>Grassville</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (if rural, give location)	
3. NAME OF DECEASED (Type or Print)	(First) <u>Virgie</u>	(Middle) <u>Vivian</u>	(Last) <u>Greenhawk</u>
4. DATE OF DEATH	(Month) <u>Feb.</u>	(Day) <u>19</u>	(Year) <u>1955</u>
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>April 25, 1890</u>
9. AGE last birthday <u>64</u> yrs.		10. If under 1 year: Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Stevensville, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Thomas Radcliffe</u>		14. MOTHER'S MAIDEN NAME <u>Margaret E/m.</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u> </u>	
17. INFORMANT AND ADDRESS <u>Husband - W.T. Greenhawk - Grassville</u>		18. MEDICAL CERTIFICATION	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
194.4 Immediate cause (a) <u>Carcinomatosis - Organ of</u>		<u>2 mo.</u>	
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>origin uncertain</u>			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION <u> </u>		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21. ACCIDENT (Specify) <u> </u> PLACE (Home, farm, factory, street, OF office bldg., etc.) <u> </u> (CITY OR TOWN) <u> </u> (COUNTY) <u> </u> (STATE) <u> </u>			
TIME (Month) (Day) (Year) (Hour) <u> </u> INJURY OCCURRED While at <input type="checkbox"/> Not While <input type="checkbox"/> At work <input type="checkbox"/> HOW DID INJURY OCCUR? <u> </u>			
22. I hereby certify that I attended the deceased from <u>Dec.</u> , 19 <u>54</u> , to <u>Feb.</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>Feb. 18</u> , 19 <u>55</u> , and that death occurred at <u>1:04</u> m., from the causes and on the date stated above.			
SIGNATURE <u>Irvin J. Holt MD</u> (Degree or title)		ADDRESS <u>Queenstown, Md.</u> DATE SIGNED <u>2/19/55</u>	
23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u> DATE THEREOF <u>2/21/55</u> NAME OF CEMETERY OR CREMATORY <u>Spring Hill Cemetery</u> LOCATION (City, town, or county) <u>Easton</u> (State) <u>Md.</u>			
DATE REC'D BY LOCAL REG. <u>2/21/55</u> REGISTRAR'S SIGNATURE <u>Helen M. Aldridge</u>		24. FUNERAL DIRECTOR <u>Mary E. Young</u> ADDRESS <u> </u>	

MAR 4 1955

RECEIVED

— 112 —

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01925

1940

CERTIFICATE OF DEATH

Reg. Dist. No. 253

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <i>Queen Anne</i>	MARYLAND	STATE <i>Ind.</i>	COUNTY <i>Queen Anne</i>
CITY (If outside corporate limits, write RURAL OR and give nearest town) X TOWN <i>Chester</i>	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <i>Chester</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>00</i>		STREET ADDRESS (If rural give location) <i>1</i>	
3. NAME OF DECEASED: (First) (Middle) (Last) <i>KENNSLEY T. GRIMES</i>		4. DATE (Month) (Day) (Year) OF DEATH: <i>Feb. 9 1955</i>	
5. SEX: <i>Male</i>	6. COLOR OR RACE: <i>W.</i>	7. (SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH: <i>Feb. 3 1955</i>
9. AGE last birthday		IF UNDER 1 YEAR	IF UNDER 24 HRS.
		Months	Days
		Hours	Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <i>None</i>	10B. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country): <i>Maryland</i>	12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>
13. FATHER'S NAME: <i>Edward E. Grimes</i>		14. MOTHER'S MAIDEN NAME: <i>Marilyn Hampton</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): <i>9</i> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. _____	
17. INFORMANT & ADDRESS: <i>Edward E. Grimes, Chester, Ind.</i>			
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE <i>770.5</i>			
(A) DUE TO <i>hemolytic crisis</i>			<i>Feb. 3. 1955</i>
ANTECEDENT CAUSE (S)			
(B) DUE TO <i>Erythroblastosis foetalis</i>			<i>Feb. 3. 1955</i>
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE, STATING UNDERLYING CAUSE LAST.			
(C) DUE TO <i>congenital debility</i>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <i>premature birth</i>			
19A. DATE OF OPERATION: <i>0</i>		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR? <i>27</i>	
22. I hereby certify that I attended the deceased from <i>Feb. 3, 1955</i> , to <i>Feb. 9, 1955</i> , that I last saw the deceased alive on <i>Feb. 9, 1955</i> , and that death occurred at <i>1:35 P.M.</i> , from the causes and on the date stated above.			
SIGNATURE <i>Theodor Sattelmaier</i>		M. D. <i>Stevensville Md. Feb. 9. 1955.</i>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
	<i>Feb. 10</i>	<i>Stevensville</i>	<i>Stevensville Ind.</i>
DATE REC'D BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
<i>Feb. 11, 1955</i>	<i>Elizabeth Wyster</i>	<i>Edgar L. Kane - Church Hill, Ind.</i>	

1025204353

MAINTENANCE STATE DEPARTMENT OF HEALTH - BUREAU

1950
OFFICE OF THE ATTORNEY GENERAL

UNITED STATES OF AMERICA

STATE OF NEW YORK
IN SENATE
JANUARY 10, 1950
REPORT OF THE
COMMISSIONER OF HEALTH
ON THE
ANNUAL REPORT OF THE
COMMISSIONER OF HEALTH
FOR THE YEAR 1949
ALBANY: J.B. LIPPINCOTT COMPANY, 1950

BUREAU V. 81

16 1955

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PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 01926

1941

CERTIFICATE OF DEATH

Reg. Dist. No. 251

Item 7, Film GL77 2-18-55 et

1. PLACE OF DEATH:

COUNTY Queen Anne MARYLAND
CITY (If outside corporate limits, write RURAL LENGTH OF STAY
OR and give nearest town) (in this place)
X TOWN Sudlersville
HOSPITAL OR
INSTITUTION OR
STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Md. COUNTY Queen Anne
CITY (If outside corporate limits, write RURAL and give nearest town)
OR
TOWN Sudlersville
STREET ADDRESS (If rural give location)

3. NAME OF DECEASED:

(First) (Middle) (Last)
HARRY HUGH HUDSON
(Type or Print)

4. DATE OF DEATH: (Month) (Day) (Year)
Feb. 11 19 55

5. SEX:

M.

6. COLOR OR RACE:

W.

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) widowed

8. DATE OF BIRTH:

Dec. 27, 1886

9. AGE last birthday: 68 yrs.

IF UNDER 1 YEAR IF UNDER 24 HRS.
Months Days Hours Min.

10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired George

10b. KIND OF BUSINESS OR INDUSTRY: Animal Repair

11. BIRTHPLACE (State or foreign country): Md.

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME:

Samuel Hudson

14. MOTHER'S MAIDEN NAME:

Lucif B. Reed

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) 9

16. SOCIAL SECURITY No.: 216-12-1311

17. INFORMANT'S ADDRESS: Mrs. Woodrow Montague, Sudlersville Md.

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

581.0
Immediate cause

(a)

DUE TO

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.

(b)

DUE TO

(c)

Cerebral 9 Linn

Interval Between Onset And Death

11. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

General Asthma - Acute Pulm

19a. DATE OF OPERATION:

0 W

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE

(Specify) W

PLACE (Home, farm, factory, street, office bldg., etc.)

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY — m.

INJURY OCCURRED While at Work ☐ Not While At Work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Oct., 1954, to Feb. 11, 1955, that I last saw the deceased alive on Feb. 9, 1955, and that death occurred at 3:30 A.M. from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION, REMOVAL (Specify)

Burial

DATE THEREOF

Feb. 13, 1955

NAME OF CEMETERY OR CREMATORY

Sudlersville Cem.

LOCATION (City, town, or county)

Sudlersville Q. A. Co. Md.

(State)

DATE REC'D BY LOCAL REGISTRAR

2-14

REGISTRAR'S SIGNATURE

Edgar L. Lane

24. FUNERAL DIRECTOR

Edward Fellows

ADDRESS

Millington Md.

BUREAU V. S.

Feb 16 1955

RECEIVED

1942

CERTIFICATE OF DEATH

Reg. Dist. No. 251

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <i>Queen Anne</i>		MARYLAND		STATE <i>Md</i>		COUNTY <i>Kent</i>	
CITY (If outside corporate limits, write OR and give nearest town) <i>Sudlersville</i>		RURAL LENGTH OF STAY (in this place) <i>2 mos.</i>		CITY (If outside corporate limits, write OR and give nearest town) <i>Millington</i>		<i>14 X - 2</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>90 Everett Nursing Home</i>				STREET ADDRESS (If rural give location) <i>✓</i>			
3. NAME OF DECEASED: (First) <i>ETHEL</i> (Middle) <i>CROUCH</i> (Last) <i>MOFFETT</i>				4. DATE OF DEATH: (Month) <i>Feb.</i> (Day) <i>3</i> (Year) <i>1953</i>			
5. SEX: <i>F.</i>		5. COLOR OR RACE: <i>W.</i>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <i>Widowed</i>		8. DATE OF BIRTH: <i>Feb. 16, 1869</i>	
9. AGE last birthday: <i>85</i> yrs.		IF UNDER 1 YEAR: Months <i>0</i> Days <i>0</i> Hours <i>0</i> Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired: <i>Housewife</i>				10b. KIND OF BUSINESS OR INDUSTRY: <i>Own Home</i>		11. BIRTHPLACE (State or foreign country): <i>Md.</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>							
13. FATHER'S NAME: <i>Edwin Crouch</i>				14. MOTHER'S MAIDEN NAME: <i>Frances Ford</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <i>No</i> (If Yes, give war or dates of service) <i>—</i>				16. SOCIAL SECURITY No.: <i>none</i>		17. INFORMANT & ADDRESS: <i>Mrs. Paul Conrags, Millington Md</i>	
18. MEDICAL CERTIFICATION							
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						Interval Between Onset And Death	
Immediate cause (a) <i>Cerebral Hemorrhage</i>							
Antecedent causes (s) (b) <i>Cerebral Arterio Sclerosis</i>							
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (c) <i>Chronic Myocarditis</i>							
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <i>Hypertension</i>							
19a. DATE OF OPERATION: <i>0 W</i>				19b. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>							
21. ACCIDENT (Specify) <i>W</i>		PLACE (Home, farm, factory, street, office bldg., etc.)		(CITY OR TOWN)		(COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY <i>—</i>		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>Nov. 19, 1953</i> , to <i>Feb. 3, 1953</i> , that I last saw the deceased alive on <i>Feb. 2, 1953</i> , and that death occurred at <i>3 P.M.</i> from the causes and on the date stated above.							
SIGNATURE <i>E. J. [Signature]</i> (Degree or title)				DATE SIGNED <i>2/4/53</i>			
23. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		DATE THEREOF <i>Feb. 6, 1953</i>		NAME OF CEMETERY OR CREMATORY <i>Millington Cem.</i>		LOCATION (City, town, or county) (State) <i>Millington Kent Co. Md</i>	
DATE REC'D BY LOCAL REGISTRAR <i>2-5</i>		REGISTRAR'S SIGNATURE <i>Edgar L. Lane</i>		24. FUNERAL DIRECTOR <i>Edward Holloway</i>		ADDRESS <i>Millington Md</i>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

FEB 9 1955

RECEIVED

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1943

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

01928

Reg. Dist. No. 253

1. PLACE OF DEATH COUNTY <u>Queen Anne's</u> MARYLAND				2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Md.</u> COUNTY <u>Q. A.</u>			
CITY (If outside corporate limits, write RURAL and OR give nearest town) <u>Chester</u>				CITY (If outside corporate limits, write RURAL and give nearest town) <u>Chester</u>			
TOWN <u>Chester</u>				TOWN <u>Chester</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural, give location)			
3. NAME OF DECEASED (Type or Print)		(First) <u>Lucy</u>		(Middle) <u>JONES</u>		(Last) <u>Roe</u>	
4. DATE OF DEATH		(Month) <u>Feb</u>		(Day) <u>15</u>		(Year) <u>1955</u>	
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>WIDOWED</u>		8. DATE OF BIRTH <u>Jan. 21 1884</u>	
9. AGE last birthday <u>71</u> yrs.		If under 1 year Months Days		If under 24 hrs. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>			
11. BIRTHPLACE (State or foreign country) <u>Md.</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>Samuel L. Jones</u>				14. MOTHER'S MAIDEN NAME <u>Catherine Thompson</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY No. <u>—</u>			
17. INFORMANT AND ADDRESS <u>Son - Albert Roe - Chester, Md</u>							
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
Immediate cause <u>175X Carcinoma of Ovary</u>						<u>1 yr.</u>	
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last							
(c)							
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.							
19a. DATE OF OPERATION <u>—</u>				19b. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>							
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.)		(CITY OR TOWN)		(COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>		HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Jan.</u> , 19 <u>51</u> , to <u>Feb.</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>Feb. 15</u> , 19 <u>55</u> , and that death occurred at <u>8:45</u> p.m., from the causes and on the date stated above.							
SIGNATURE <u>Irwin D. Hoyt M.D.</u>				ADDRESS <u>Queentown Md.</u>		DATE SIGNED <u>2/15/55</u>	
23. BURIAL, CREMATION REMOVAL (Specify) <u>BURIAL</u>		DATE THEREOF <u>FEB. 18, 1955</u>		NAME OF CEMETERY OR CREMATORY <u>STEVENSVILLE CEMETERY</u>		LOCATION (City, town, or county) (State) <u>STEVENSVILLE, MARYLAND</u>	
DATE REC'D BY LOCAL REG. <u>Feb. 18-1955</u>		REGISTRAR'S SIGNATURE <u>Elizabeth Hoyt</u>		24. FUNERAL DIRECTOR <u>W. Thompson Carroll, Easton, Md.</u>		ADDRESS	

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FEB 23 1955

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1944
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01929

Reg. Dist.

No. 252

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Queen Anne</u>		MARYLAND		STATE <u>MD</u>		COUNTY <u>Queen Anne</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN <u>near Centerville</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town) TOWN <u>Centerville RZU</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>James</u>				STREET ADDRESS (If rural, give location) <u>1</u>			
3. NAME OF DECEASED: (First) (Middle) (Last) <u>James Bernard Slaughter</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>Feb 9 - 1955</u>			
5. SEX: <u>male</u>	6. COLOR OR RACE: <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH: <u>June 1-1920</u>	9. AGE last birthday: <u>34</u> yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <u>Talbot Co Md</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		
13. FATHER'S NAME: <u>Bernard Slaughter</u>				14. MOTHER'S MAIDEN NAME: <u>Ann E. Callahan</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>no</u>		16. SOCIAL SECURITY No.: <u>none</u>		17. INFORMANT & ADDRESS: <u>Clara Lloyd Slaughter - wife</u>			
18. MEDICAL CERTIFICATION							INTERVAL BETWEEN ONSET AND DEATH
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:							
<p><u>824 X</u> Immediate cause (a) <u>Auto accident - Broken neck + asphyxia</u> DUE TO</p> <p>Antecedent cause(s) (b) _____ Diseases or conditions, if any, giving rise to the above cause DUE TO _____ stating underlying cause last (c) _____</p>							
11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION: <u>Feb 9-55-945 AM</u>				19b. MAJOR FINDING OF OPERATION:			20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY <u>Co-road</u>		21c. (City or town) (County) <u>near Centerville - 2c</u> <u>MD</u>		(State)	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>Feb 9-55-945 AM</u>		21e. INJURY OCCURRED While at <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>Fell, or thrown from truck.</u>			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE <u>W. Henry Fisher</u>		CHIEF MEDICAL EXAMINER		DEPUTY MEDICAL EXAMINER		DATE SIGNED <u>2/10-55</u>	
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>		DATE THEREOF: <u>Feb. 12, 1955</u>		NAME OF CEMETERY OR CREMATORY: <u>Springhill</u>		LOCATION (City, town, or county) (State): <u>Easton, Maryland</u>	
DATE REC'D BY LOCAL REG. <u>2-11-55</u>		REGISTRAR'S SIGNATURE: <u>Clara Armstrong</u>		24. FUNERAL DIRECTOR: <u>Barton Bros. Centerville, Maryland</u>		ADDRESS	

BUREAU V. S.

FEB 21 1995

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